
*Report of the
Governor's
Mental Health System
Task Force*

*Presented to
Mike Huckabee,
Governor
State of Arkansas
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The State of the State's Public Mental Health System

A Preamble to the Report of the Governor's Mental Health System Task Force

Where we are

The demand for services to meet the critical needs of mentally ill adults and emotionally disturbed youth in our communities continues to grow while the services available are not increasing and in fact are shrinking in many parts of the state. The services that are available too often do not include those most appropriate to meet the needs of our people.

Arkansas is not alone in this crisis of care for people with mental illness. The challenges we face also confront most states in this country. The indications of a disintegrating system are clear in spite of significant increases in our expenditures for mental health services through the Medicaid program.

We are told that the annual expenditure of public funds to pay for mental health services in Arkansas including Medicaid reimbursements now approaches \$400 million. We spend more and yet serious problems remain.

Why is this? It is partly because so much of what we spend on mental health services in Arkansas is spent on very expensive inpatient psychiatric care for a relatively small number of people. Almost everyone involved in the public mental health system—professionals, providers, consumers and would-be consumers, their families, and their advocates—agrees that many of these patients could be well-cared for in less intensive, less expensive settings if they were readily available across the state.

But it is also partly because Arkansas, like most of the rest of the country, has failed for decades to make significant changes in the *system* unless spurred to do so by some tragic set of circumstances involving violent acts by one or more persons suffering with lifelong psychiatric illness.

Community hospitals with psychiatric units working with their local community mental health centers had nearly 5,000 admissions to those units last year. Most of those hospitals have closed their psychiatric units because our *system* denied them an avenue by which they could be paid for the care provided to persons who could not pay and who had no insurance that would do so. Since Arkansas is forty-ninth in the country in the number of state-operated psychiatric beds per one hundred thousand population, the State Hospital cannot take up the slack created by these closings. As a result, there is every reason to anticipate that in the coming year hundreds of seriously mentally ill persons who present a “clear and present danger to themselves and others, and therefore are in need of acute inpatient psychiatric care, will be denied that care. They will remain in their communities without adequate care until their behavior brings them to the attention of local law enforcement and they are placed in county or municipal jails for

their own protection or to protect the community. This, of course, will place further strain on the jails and their personnel who are already struggling to care for dozens of inmates awaiting court-ordered psychiatric treatment or evaluations at the Arkansas State Hospital—which is too full to take them on a timely basis.

The situation with children and adolescents is as bad, perhaps worse, with a serious shortage of alternative services to prevent unnecessary hospitalization. As a result, far too many youth are being placed in expensive, restrictive hospital beds or other inpatient settings in Arkansas or out-of-state. They are being removed from their families, from their schools, from their communities—often only because our public mental health system does not provide appropriate alternative programs or services.

The Surgeon General of the United States pointed out in his report on mental health in America that during the course of a year 20% of the children in our country experience the signs and symptoms of a diagnosable mental health problem. Assuming that estimate is accurate, Arkansas has well over 100,000 children and youth experiencing such difficulties. But last year our *public mental health system* provided care to only about 20,000 young people, or one out of five who needed such care.

Therefore, we believe the plight of children in Arkansas can be described thus: many preventable and treatable emotional and behavior problems are going unattended and getting worse because our *system* of care is inadequate in terms of the limited range, availability, and appropriateness of services; numbers of trained mental health personnel; and funding.

There have been recent changes in the state's Medicaid program intended to manage the exploding costs of outpatient mental health care for Arkansans under age twenty-one and to ensure that services being provided are medically necessary. However, it is extremely important also to ensure that these changes do not unnecessarily limit access to needed care.

And what we need to do

We must understand there are no easy answers, no simple solutions, to these issues. Years of benign neglect of the public mental health system and the failure of many components of that system to change—to embrace new and better ways of providing care—have combined to bring us to the critical juncture we now face.

We must evaluate Arkansas's public mental health system and hold those who manage it accountable for the effectiveness of the services they provide and for the public funds they control. We must be willing to consider new approaches to financing and providing care for our mentally ill and the emotionally disturbed people. And we need to do it as quickly as we can.

We must examine and revise as necessary the laws and public policies that enable our public mental health system and define its responsibilities and authority. We must continue to include all those who have a stake in the system in our diligent search for better policy and more responsive and effective service systems.

We must together rethink the public mental health system; strengthen accountability for access, availability, and quality of care; support effective community-based services; push for reliance on evidence-based practices in mental health care; and create stable and adequate mechanisms for funding mental health services.

California's Little Hoover Commission, in its publication *Being There: Making a Commitment to Mental Health*, said that "what sets mental health apart from other social and medical causes is that we do not share a collective expectation or sense of responsibility—and as a result, there is little outrage when mental health programs fail."

Please consider this report from those of us on the Task Force to be an expression of outrage at the failures of Arkansas's public mental health system and a plea that the recommendations the report contains be implemented now. The sixty thousand Arkansans who depend on the system can't wait.

Introduction

The Governor's Mental Health System Task Force was composed of sixteen Arkansans from all across the state. Some are mental health professionals, educators, and administrators. Some are mental health service consumers, their family members, or their advocates. Others are members of the judiciary or the bar, while still others are "simply" concerned citizens.

All of us have in common our concern for the health and well being of those members of our communities who suffer from the frequently misunderstood and almost always stigmatizing labels of *mentally ill* or *emotionally disturbed*.

We met regularly from August 2001 through May 2002. We came together as a full Task Force, and we met in smaller work groups to think through and put into words the recommendations contained in this report to the state's Chief Executive.

One of the work groups focused on the two facilities operated by the Division of Mental Health Services, the Arkansas State Hospital and the Arkansas Health Center. The second looked at locally provided services for people with acute mental illness or emotional disturbance, while the third targeted the broader array of community-based mental health services.

Members of the administrative staff of the Division of Mental Health Services aided the Task Force in its work by serving as resource persons to the work groups and to the Task Force as a whole.

As part of our work, the Task Force adopted the following working definition of the *Arkansas Public Mental Health System* to assist us in directing our efforts most appropriately:

The Arkansas Public Mental Health System is composed of...

- ...Facilities, programs, and services directly administered by the Arkansas Division of Mental Health Services.
- ...Facilities, organizations, and programs receiving funding from or through the Division of Mental Health Services to provide mental health services, including advocacy, education, and referral services, regardless of the source or nature of that funding.
- ...Mental health services paid for by the Arkansas Division of Medical Services through the state's Medicaid Program.
- ...Advisory councils, task forces, or public awareness efforts organized or sanctioned by the Division of Mental Health Services that address issues related to mental health services, including advocacy, education, and referral services.

This report contains the recommendations that we, the Governor's Mental Health System Task Force, agreed should be submitted to Arkansas's Chief Executive on behalf of the more than 60,000 citizens currently being served by the state's public mental health system—and on behalf of the tens of thousands more who, unfortunately, need to be served but are not.

The Governor's Mental Health System Task Force

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The Task Force's Recommendations

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As the mental health authority for Arkansas, the Division of Mental Health Services must be empowered by the Department of Human Services, the General Assembly, and the Governor's Office to make and implement needed mental health public policy and to participate actively in decision-making processes within other state agencies that may be expected to affect the availability and/or the quality of mental health services in Arkansas, and should be held accountable for doing so efficiently and cost-effectively.

A. The Division of Mental Health Services must be actively involved in planning and decision-making undertaken by the Division of Medical Services specifically related to Medicaid reimbursement for mental health services, including the development of proposals to contract for prior authorization services and/or changes in the methods or standards for the determination of medical necessity.

B. The Division of Mental Health Services must have access to any information available through other state agencies that will assist it in the planning for or monitoring of mental health services. This should include but not be limited to reports, surveys, and other data that is or can reasonably be generated by the Division of Medical Services or its contractors. The Division of Mental Health Services must also have or have access to the qualified personnel and technology required to use such information expeditiously.

C. In shaping the major policies and making decisions that affect the state's public mental health system, the director of the Division of Mental Health Services must actively seek input from system stakeholders. These stakeholders should include but not be limited to the Arkansas Mental Health Planning and Advisory Council, the Arkansas Chapter of the National Alliance for the Mentally Ill and other appropriate consumer and advocacy organizations, the Department of Health, the Department of Education, directors of the community mental health centers, the Arkansas Hospital Association, the Child and Adolescent Services System Program (CASSP) Coordinating Council, and the Department of Human Services' Divisions of Children and Family Services, Youth Services, Developmental Disabilities Services, and Medical Services.

All existing statutes and all policies and regulations promulgated by the Division of Mental Health Services governing the roles, responsibilities, and accountability of certified community mental health centers and clinics in Arkansas should be reviewed and updated to assure a uniform, statewide baseline level of availability, accessibility, and quality of a prescribed array of publicly supported community-based mental health services for citizens of all ages, including those with mental illness and co-occurring substance abuse or developmental disorders.

A. The Division of Mental Health Services should update *the Standards for Community Mental Health Centers and Clinics in the State of Arkansas*. The updated version should detail the role and functions of the Standards Review Committee and should clarify the relationship between the *Standards* and national accreditation.

B. The updated *Standards* should incorporate systematic procedures such as site visits or other on-site review mechanisms for assuring compliance in those provider operational areas that are not adequately monitored by the accreditation surveys of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Council on Accreditation of Rehabilitation Facilities (CARF).

C. The language of the contracts between the Division of Mental Health Services and community mental health centers should be revised in order to:

1. More clearly identify the services the centers are required to provide,
2. Specify the *access* and *evidence-based outcome standards* to be used in evaluating the centers' performance,
3. Identify the target populations to be served,
4. Require each center to participate actively with the Arkansas State Hospital staff in coordinated discharge planning for individuals from its service area, and
5. Encourage systematic development of collaboration between centers and local law enforcement agencies.

D. The Division of Mental Health Services should use its existing regulatory and funding authority to assure the statewide availability of a prescribed array of publicly supported community-based mental health services for citizens of all

ages, including those with co-occurring disorders of substance abuse and mental illness or developmental disability and mental illness.

E. The Department of Human Services should seek from the General Assembly the resources needed to adequately fund CASSP to fulfill its full purpose of “coordinated [children’s mental health] policy development” as set forth in Act 1517 of 2001. The Departments of Human Services, Education, and Health should be required to use the Child/Adolescent Services System Program (CASSP) Coordinating Council to assure appropriate collaboration in the development of any policy or plan by these three Departments that will affect Arkansas’s children’s mental health system.

F. The Division of Mental Health Services and the Department of Education should establish a coordinated plan to assure, with recent Medicaid State Plan changes making it possible for school districts to become providers of Medicaid-reimbursed mental health services, that existing school-based mental health services are maintained and fragmentation within the system of care is averted.

G. The Division of Mental Health Services, recognizing that many of the state’s counties are sparsely populated and that mental health resources are limited, should develop adequately funded regional community-based systems that assure the availability around the state of critical and often expensive psychiatric acute care services. Such services should include but not be limited to inpatient care, crisis stabilization, mobile crisis teams, jail diversion programs, evidence-based wrap-around intensive case management services such as Assertive Community Treatment (ACT), and family support services.

The Governor’s Office and the Director of the Department of Human Services should strongly encourage the Arkansas General Assembly, having sought advice from system stakeholders, to take the following actions:

A. Amend the Mental Health Parity Act of 1997 to require that all private health insurance plans marketed in Arkansas provide treatment for mental illness and substance abuse commensurate with that provided for major physical illnesses and offer access to all effective and medically necessary psychiatric medications.

B. Fully fund Act 1589 of 2001 to provide for local indigent psychiatric inpatient care, and enact additional legislation necessary to support local, readily available alternatives to hospitalization—such as intensive case management like the Assertive Community Treatment (ACT) model, crisis stabilization services,

and mobile crisis services—throughout the state. Additional funding mechanisms should be developed so that broad access to mental health services is retained without the addition of barriers such as co-pays or reductions in currently covered services.

C • Update current commitment laws to expand commitment criteria while protecting the civil rights of Arkansans.

D • Review and modify the single point of entry (SPOE) system for persons being considered for admission to the Arkansas State Hospital to reflect current circumstances and to reinforce the objective of assuring appropriate admissions to and discharges from the Arkansas State Hospital.

Potential modifications to Arkansas's Medicaid State Plan, including various waivers, must be aggressively pursued to assure the availability of Medicaid reimbursement for newer, more effective, and more efficient evidence-based mental health services.

A • The Medicaid State Plan and the Medicaid Rehabilitation Services for Persons with Mental Illness (RSPMI) program should be updated to provide for reimbursement for recently developed services, including wrap-around case management such as Assertive Community Treatment (ACT), mobile crisis teams, family-oriented interventions, and a broader range of family and children's mental health services.

B • The Arkansas Medicaid Program should be expanded to cover substance abuse treatment services to assure the integrated care and treatment of persons with co-occurring mental and addictive disorders.

C • Any Medicaid requirement of prior authorization for outpatient mental health services should focus on the most intensive and expensive services, or on those people whose utilization of services significantly exceeds the norm, rather than on routine short-term or maintenance services.

D • Any proposed change to the Arkansas Medicaid State Plan that will limit, restrict, or eliminate access to existing mental health benefits must contain an impact statement indicating any cost shifting that will result from the change. The impact statement shall include but not be limited to identifying (1) other systems serving children and adults who will be affected by the change; (2) the dollar amount

that will be shifted to those other systems; (4) the number of children, adolescents, and adults the change will affect; and (5) the outcomes expected from the change.

E. The Division of Medical Services should require all early periodic screening, diagnosis, and treatment (EPSDT) screenings to include a screening instrument, jointly approved by the Division Medical Services and the Division of Mental Health Services, designed to identify mental health and addiction issues in the under-21 population. The instrument should be one that can be quickly and efficiently administered by personnel appropriately trained to use mental health and substance abuse treatment resources.

F. Arkansas should aggressively pursue amendments to the Medicaid State Plan that would allow an upper payment limit (UPL) approach designed to provide enhanced adult psychiatric inpatient acute care through the Arkansas State Hospital, University of Arkansas for Medical Sciences (UAMS) University Hospital, community hospitals, and other inpatient and outpatient providers across the state.

G. An adult psychiatric acute care unit should be opened at University Hospital to supplement the capacity of the Arkansas State Hospital.

H. The state's Congressional Delegation should be strongly encouraged to support the removal of the Institution for Mental Diseases (IMD) exclusion currently mandated by federal statute.

I. All possible avenues to secure Medicaid funding for medically indigent mentally ill patients who are hospitalized in community hospitals should be pursued fully.

The roles, target populations, and admission and discharge policies of the Arkansas State Hospital and the Arkansas Health Center must be reevaluated and revised to assure their cost-effectiveness, their most appropriate utilization, and equitable access for citizens from all areas of the state.

A. Access to acute-care psychiatric and forensic beds at the Arkansas State Hospital should be increased in the following ways:

1. Creating local hospital diversion programs,
2. Developing facilities for long-term patients whose conditions do not require acute care,
3. Providing funding for indigent care in local hospital psychiatric units, and
4. Expanding outpatient prevention-of-hospitalization programs.

B. A plan should be developed to assure equitable access to admission to the Arkansas State Hospital's acute-care beds for citizens from all areas of the state.

C. The Arkansas Health Center's mission statement should be revised to underscore its primary function of serving people with special needs, especially those with co-occurring medical and behavioral health disorders, who cannot be adequately cared for in other nursing facilities.

1. The types of residents who can be cared for on each of the facility's units should be determined and clearly stated in written policies.
2. Those current residents who can be adequately served in a less restrictive setting should be identified.
3. An action plan should be developed to implement indicated changes in resident placements.

D. The Arkansas Health Center should become a training center appropriately staffed and funded to provide state-of-the-art training for nursing home personnel from across the state in the care of residents with complex problems who are difficult to manage.

E. A long-range plan to modernize and improve the Arkansas Health Center should be developed, and it should include the completion of Phase II of the original design of the skilled nursing care facility on the campus.

All necessary steps must be taken to ensure the availability of a well-trained, stable, culturally diverse and culturally competent corps of mental health professionals and paraprofessionals including psychiatrists, psychologists, social workers, professional counselors, nursing personnel at all levels, case managers, and other mental health workers.

A. The Division of Mental Health Services should require that cultural diversity education and training of all staff at all levels within the Division and public mental health system providers be established as a part of staff competencies and preparedness.

B. The Division of Mental Health Services should make the recruitment, career advancement and retention of a culturally diverse staff a priority for the

Division and for providers in the public mental health system of Arkansas.

C • The public mental health system of Arkansas, through the leadership of the Division of Mental Health Services, should emphasize culturally sensitive education and prevention services for consumers, families, and communities regarding mental health disorders and treatment approaches.

D • To increase the number and cultural diversity of mental health professionals, the Division of Mental Health Services should propose to the Governor and the General Assembly a program to establish financial assistance and loan-forgiveness programs for those studying to become mental health professionals who agree to practice in areas designated as medically underserved.

E • The Division of Mental Health Services should develop a Multicultural Advisory Board that will function under the oversight of the Division's assistant director for cultural diversity and minority affairs and/or the Arkansas Mental Health Planning and Advisory Council.

Closing Comments

There are no easy answers for the many critical issues facing Arkansas's public mental health system, and we are not alone. Virtually every challenge we now face to adequately address the needs of our mentally ill adults and emotionally disturbed youth is one with which most of the states in our great nation are struggling.

But the stakes are too high—too high in human suffering, too high in lost potential—for us to be deterred by the fact that finding answers will be difficult. We must explore all potential solutions

The members of the Governor's Mental Health System Task Force are grateful to Governor Huckabee for inviting us to rise to this challenge by serving on this working group. Ours has been a tremendously important and timely task, and we have undertaken our work with dedication and a well-justified sense of urgency.

These recommendations are submitted with the full understanding that some will require action by the General Assembly if they are to be implemented. Others can be accomplished with existing resources and the authority already given to the executive branch of our state government. Some can be put in place on a stand-alone basis, while others will work only if supported by one or more of the other recommendations.

The members of the Task Force are firmly convinced that each of the recommendations contained in this report has the potential to make life better for those who suffer from both the disabling effects of chronic mental illness or serious emotional disturbance and from the lack of understanding and compassion with which they are too often confronted. We are also convinced that the implementation of these recommendations will ultimately enhance the quality of life for all citizens in our beloved state.

This Task Force was not equipped to determine the cost of implementing those recommendations that will require additional expenditures or to calculate the savings to be generated by implementing those that will result in a more effective and efficient public mental health system. However, we do strongly encourage the Governor's Office, the General Assembly, and/or the Department of Human Services, in consultation with mental-health stakeholders, to contract with qualified experts to undertake a study to make those determinations.

It is the opinion of the Task Force that the Department of Human Services should fully evaluate potential cost benefits and service delivery enhancements associated with alternate methods of distributing all public monies expended by the Department, both state and federal, for the provision or purchase of mental health services. Whether this Task Force is asked to be part of that evaluation or a new one is appointed, we believe that active participation in that process by a citizens group like ours is critically important to the ultimate success of such an effort.

And finally, Governor Huckabee, we ask that, if you find merit in our recommendations, you use your executive authority to assure that the Department of Human Services and the Division of Mental Health Services commit themselves to the timely and appropriate implementation of those recommendations.